

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9 Film 238 1-26-59 et 1109 1 79 I 01106 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 62 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMILY M. BLADES		4. DATE OF DEATH JANUARY 11 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 12, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	9. AGE (In years last birthday) 61 62 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE T. NELSON		14. MOTHER'S MAIDEN NAME LAURA GALE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 217-09-5286	
17. INFORMANT Ruth Matthews, 4905 Wright Ave., Balto. 5, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 20 hours 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 10, 19 59 , to Jan 11, 19 59 , that I last saw the deceased alive on Jan 11, 19 59 , and that death occurred at 2:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton M.D.		ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND DATE SIGNED 1/12/59	
PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D.		CRISFIELD, MARYLAND	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF Jan 13, 1959	22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		ADDRESS	
24a. REC'D BY REGISTRAR JAN 16 59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Priddy	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES E. HENRY		M		35		JAN 15 1900		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
JAN 20 1935		10:15 AM		10		15		00	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF NURSE		NAME OF ASSISTANT		NAME OF ATTENDING	
DR. J. H. SMITH		DR. W. E. JONES		MISS M. L. BROWN		MR. J. K. WHITE		MR. R. T. GREEN	
NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF INTERMENT		NAME OF MONUMENT	
JAMES E. HENRY CO.		GREENWOOD CEMETERY		GREENWOOD CEMETERY		GREENWOOD CEMETERY		GREENWOOD CEMETERY	
NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES	
MR. J. K. WHITE		MR. R. T. GREEN		MR. J. H. SMITH		MR. W. E. JONES		MR. M. L. BROWN	
NAME OF REGISTRAR		NAME OF REGISTRAR		NAME OF REGISTRAR		NAME OF REGISTRAR		NAME OF REGISTRAR	
MR. J. K. WHITE		MR. R. T. GREEN		MR. J. H. SMITH		MR. W. E. JONES		MR. M. L. BROWN	

1104
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	c. LENGTH OF STAY IN 1b Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 125 Chesapeake Ave.		d. STREET ADDRESS 125 Chesapeake Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SUSIE Middle AMELIA Last BYRD		4. DATE OF DEATH Month January Day 1 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Crisfield, Md.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Jesse B. Evans	
14. MOTHER'S MAIDEN NAME Lottie Elizabeth Horner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Chester Tyler--125 Chesapeake Ave.--Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis - 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Hemiplegia, left.			INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia, left.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 1956 , to Jan 1, 1959 that I last saw the deceased alive on 12:10 P.M. , and that death occurred at 12:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. G. Rawley M.D.		ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED Jan 8 1959	
PHYSICIAN'S NAME (Type) C. G. Rawley, M. D.		Main St.--Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 3, 1959	22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR DATE JAN 8 1959	
24b. REGISTRAR'S SIGNATURE William S. Kenna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. PLACE OF DEATH [Illegible]		10. DATE OF DEATH [Illegible]	
11. SIGNATURE OF PHYSICIAN [Illegible]		12. SIGNATURE OF REGISTRAR [Illegible]	
13. SIGNATURE OF WITNESS [Illegible]		14. SIGNATURE OF DECEASED [Illegible]	
15. SIGNATURE OF NEXT OF KIN [Illegible]		16. SIGNATURE OF CLERK [Illegible]	
17. SIGNATURE OF CHURCH CLERK [Illegible]		18. SIGNATURE OF BURIAL CLERK [Illegible]	
19. SIGNATURE OF INTERMENT CLERK [Illegible]		20. SIGNATURE OF FUNERAL HOME [Illegible]	
21. SIGNATURE OF CEMETERY CLERK [Illegible]		22. SIGNATURE OF RECORDS CLERK [Illegible]	
23. SIGNATURE OF HEALTH DEPARTMENT CLERK [Illegible]		24. SIGNATURE OF STATE DEPARTMENT CLERK [Illegible]	
25. SIGNATURE OF COUNTY CLERK [Illegible]		26. SIGNATURE OF CITY CLERK [Illegible]	
27. SIGNATURE OF TOWNSHIP CLERK [Illegible]		28. SIGNATURE OF VILLAGE CLERK [Illegible]	
29. SIGNATURE OF POST OFFICE CLERK [Illegible]		30. SIGNATURE OF SCHOOL CLERK [Illegible]	
31. SIGNATURE OF CHURCH CLERK [Illegible]		32. SIGNATURE OF SYNAGOGUE CLERK [Illegible]	
33. SIGNATURE OF MOSQUE CLERK [Illegible]		34. SIGNATURE OF TEMPLE CLERK [Illegible]	
35. SIGNATURE OF OTHER CLERK [Illegible]		36. SIGNATURE OF OTHER CLERK [Illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01108

Reg. Dist. No.

1110

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 27 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle V. Last CARVER		4. DATE OF DEATH Month JANUARY Day 7 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878-7-28-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (In years last birthday) 80-82 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. C. BEAUCHAMP		14. MOTHER'S MAIDEN NAME VIRGINIA RIGGIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-1131	
17. INFORMANT FREDERICK WILKINS, WESTOVER, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Coronary Arteriosclerosis (Embolus?) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Degenerative myocardial disease DUE TO Chronic Diffuse Myocardial Disease			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 7, 1958 to Jan 7, 1959 , that I last saw the deceased alive on Jan 7, 1959 , and that death occurred at 9:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) MARION, MARYLAND DATE SIGNED			
ACTUAL SIGNATURE George C. Coulbourn M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.,		MARION, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-10-59	22c. NAME OF CEMETERY Manokin Presbyterian	22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		24a. REC'D BY REGISTRAR JAN 12 '59	24b. REGISTRAR'S SIGNATURE Charles E. Travis

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1000

[illegible]

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11. *Journal of the American Medical Association*, 277: 1005-1006, 1997.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ella Pheobe Culver		4. DATE OF DEATH Jan. 11 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Ruark		14. MOTHER'S MAIDEN NAME Pheobe Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Vergil Marriner Princess Anne,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1956 , to Jan 11, 1959 , that I last saw the deceased alive on Jan 10, 1959 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B. Frank Giganti M.D.		ADDRESS (Street, city or town, state) 20 Prince William St Princess Anne Md.	
DATE SIGNED 1/12/59			
PHYSICIAN'S NAME (Type) B. FRANK GIGANTI			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/13/59	22c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian	
22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE James L. Luman		ADDRESS Princess Anne Md.	
24a. REC'D BY REGISTRAR JAN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01110

Reg. Dist. No.

1105

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 18 Elzie Lane				d. STREET ADDRESS 18 Elzie Lane			
3. NAME OF DECEASED (Type or print) First MAGGIE Middle A. Last ELZIE				4. DATE OF DEATH Month January Day 25 , Year 1959			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1880	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78		IF UNDER 24 HRS. Days 78 Hours 78 Min. 78			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles H. Elzie, 18 Elzie Lane, Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Generalized Arteriosclerosis (b) Cerebral Arteriosclerosis (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 yrs.							
INTERVAL BETWEEN ONSET AND DEATH 12 hrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 25, 1959 , to Jan 25, 1959 , that I last saw the deceased alive on Jan 25, 1959 , and that death occurred at 8:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED 1/29/59							
ACTUAL SIGNATURE Sarah M. Peyton M.D. 33 W. Main St							
PHYSICIAN'S NAME (Type) Sarah M. Peyton, M. D.				Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 29, 1959		22c. NAME OF CEMETERY OR CREMATORY Lawsonia Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.				ADDRESS		24a. REC'D BY REGISTRAR FEB 2 1959	
						24b. REGISTRAR'S SIGNATURE Arthur S. Acord	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
WILLIAM BROWN		45		Male		White		1910		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Residence		Marital Status		Education		Previous Illness		Last Seen Alive		Burial Place		Burial Date		Burial Time		Burial Signature		Burial Date	
Farmer		Barnstable, Mass.		Married		High School		None		10:00 AM		Barnstable		1910		10:00 AM		[Signature]		1910	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #1		f. STREET ADDRESS Rt. #1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle T. Last HALL		4. DATE OF DEATH Month January Day 13, Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1873
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Marion, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert L. Hall		14. MOTHER'S MAIDEN NAME Phoebe Lambden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert O. Hall, Rt.#1, Marion, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bilob Hunt 422.1 DUE TO Chronic out nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Chronic hypertension (b) Chronic hypertension (c) Chronic hypertension		INTERVAL BETWEEN ONSET AND DEATH 24 hrs Year Yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arterio Sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 13 , 19 59 , to Jan 13 , 19 59 , that I last saw the deceased alive on Jan 13 , 19 59 , and that death occurred at 9:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George C. Coulbourn		ADDRESS (Street, city or town, state) Marion, Md.	
PHYSICIAN'S NAME (Type) George C. Coulbourn, M. D.		DATE SIGNED Marion, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 16, 1959	22c. NAME OF CEMETERY OR CREMATORY Rehobeth Baptist Cemetery	22d. LOCATION (City, town, or county) (State) Rehobeth, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR 19 59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CLERK

NAME OF RECORDER

1113

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 24 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION STATION			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.				d. STREET ADDRESS Box 300		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle THOMAS Last HANDY				4. DATE OF DEATH Month JANUARY Day 27 Year 1959			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1884		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN THOMAS HANDY				14. MOTHER'S MAIDEN NAME MARIA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT ROBERT HANDY		Address MARION STATION, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Sudden Heart Arrhythmia 157X DUE TO Carcinoma of Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Chronic Intestinal Chronic myeloid							INTERVAL BETWEEN ONSET AND DEATH None Less
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema & Chronic Kidney							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1 , 1958, to Jan 27 , 1959, that I last saw the deceased alive on Jan 27 , 1959, and that death occurred at 12:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE George C. Coulbourn M.D.				MARION STATION, MD.			
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.,				MARION STATION, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 1-1959		22c. NAME OF CEMETERY OR CREMATORY Branch		22d. LOCATION (City, town, or county) (State) MARION, SOM, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H Ward				ADDRESS Marion Md.		24a. REC'D BY REGISTRAR Feb 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Charles Henry Marion, Md.
Burial Oct 1-1921 Branch

Marion, Son, W.D.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
CERTIFICATE OF DEATH

NAME		JAMES MARION	
AGE		32 YEARS	
SEX		MALE	
RACE		WHITE	
BIRTH		JANUARY 11, 1889	
DEATH		OCTOBER 1, 1921	
PLACE		BALTIMORE, MARYLAND	
CAUSE		TUBERCULOSIS OF LUNGS	
MANNER		NATURAL	
SIGNATURE		JAMES MARION	
WITNESSES		JAMES MARION	
REGISTRAR		JAMES MARION	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MARYLAND	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1114

CERTIFICATE OF DEATH

01113

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edgie Middle Clifford Last Harris				4. DATE OF DEATH Month January Day 20 , Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 8, 1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jabrus Harris				14. MOTHER'S MAIDEN NAME Louvinia Dayton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-14-1516		17. INFORMANT Address Mrs. William Owens, Princess Anne, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pharynx DUE TO 191.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Left Temporal lobe DUE TO 14 yrs. (c) marked malnutrition						INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 20, 1958 to Jan 20, 1959 that I last saw the deceased alive on Jan 20, 1959 , and that death occurred at 11:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. C. Lewis		M.D. Princess Anne, Md.		DATE SIGNED 1/21/59			
PHYSICIAN'S NAME (Type) A. C. Lewis, M.D. Princess Anne, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/22/59		22c. NAME OF CEMETERY OR CREMATORY St Johns		22d. LOCATION (City, town, or county) (State) Deal Island Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Herman		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR JAN 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. House	

1113

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 66 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT W. HOWETH, SR.		4. DATE OF DEATH JANUARY 7 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAFOOD		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES W. HOWETH		14. MOTHER'S MAIDEN NAME LORA DODSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 214-34-8516	
17. INFORMANT MARIAN HOWETH, CRISFIELD, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dec 7 Heart Wrecks 158X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) supraventricular tachycardia DUE TO (c) Pericardial Carcinoma INTERVAL BETWEEN ONSET AND DEATH 1 month Yes 2 Yes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arterio Sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 7 1957 to Jan 7 1958 , that I last saw the deceased alive on Jan 7 1958 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND DATE SIGNED			
ACTUAL SIGNATURE George C. Coulbourn M.D.			
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D., CRISFIELD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 9, 1958	22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Park	22d. LOCATION (City, town, or county) (State) Crisfield, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		24a. REC'D BY REGISTRAR Jan 12 '59	
		24b. REGISTRAR'S SIGNATURE Colton S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1116

item 9 FilmG237 1-12-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Hill		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Hill		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Henry		Middle Augustus		Last Johnson		4. DATE OF DEATH Month January		Day 3,		Year 1959		5. SEX Male		6. COLOR OR RACE Col.					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1872		9. AGE (In years last birthday) 86 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Raw Bar Attendant		11. BIRTHPLACE (State or foreign country) Upper Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Emma Johnson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-0009		17. INFORMANT Cecelia Johnson		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Upper Hill, Maryland		(County) Somerset		(State) Maryland		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE R. H. Johnson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/6/59	
EXAMINER'S NAME (Type) R. H. Johnson, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 8, 1959		22c. NAME OF CEMETERY OR CREMATORY Upper Hill Cemetery		22d. LOCATION (City, town, or county) Upper Hill, Maryland		(State) Somerset		23. FUNERAL DIRECTOR'S SIGNATURE William H. James		ADDRESS Upper Hill, Maryland		24a. REC'D BY REGISTRAR DATE 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE IN BOX
DATE

DECEASED

RESIDENT OF

AGE
SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

US BIRTH

ALIEN

DATE OF ENTRY

REASON FOR ENTRY

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

TRAUMA

POISONING

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

UNKNOWN

OTHER

REMARKS

SIGNATURE

DATE

PLACE

STATE

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G241 4-21-59 et

011116

1117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chance				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie Middle B. Last Jones				4. DATE OF DEATH Month I Day I7 Year 1959			
5. SEX Female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH I/26/1954	
9. AGE (In years last birthday) 7 yrs. 4		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A.							
13. FATHER'S NAME George HUTT				14. MOTHER'S MAIDEN NAME Martje Gale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT George HUTT, Chance Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 17, 1959 , to Jan 17, 1959 , that I last saw the deceased alive on Jan 17, 1959 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Eldon G. Mankwan M.D. Princess Anne, Md. PHYSICIAN'S NAME (Type) ELDON G. MANKWAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF I/21/59		22c. NAME OF CEMETERY OR CREMATORY George Town		22d. LOCATION (City, town, or county) (State) George Town, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR				ADDRESS PRINCESS ANNE, MD		24a. REC'D BY REGISTRAR Jan 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01117

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1118

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne	c. LENGTH OF STAY in lb life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Vergil First Clyde Middle Marriner Last		4. DATE OF DEATH January 31, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1894
9. AGE (In years, months, days) 64 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Frank W. Marriner		14. MOTHER'S MAIDEN NAME Sarah Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 221-16-2621	
17. INFORMANT Clyde Marriner, Princess Anne, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shot gun wound 7 lead 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Right Temporal Area (a), stating the underlying cause last. DUE TO (c) Right Parietal Area		INTERVAL BETWEEN ONSET AND DEATH 0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot gun blast	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:40 p. m. 1-31-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boys home		20f. CITY OR TOWN (County) (State) Princess Anne Somerset Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.H. Johnson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.H. Johnson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Feb 3-1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/59	
22c. NAME OF CEMETERY OR CREMATORY Beechwood Memorial		22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Linn		ADDRESS Princess Anne, Md.	
24a. REC'D BY REGISTRAR FEB 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK
HEALTH DEPT.

1118

MARY AND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: Robert
AGE: 11
SEX: Male
RACE: White
BIRTH DATE: 11-11-1904
BIRTH PLACE: St. Louis, Mo.
RESIDENCE: St. Louis, Mo.
OCCUPATION: Student

DATE OF DEATH: 11-11-1918
PLACE OF DEATH: St. Louis, Mo.
CAUSE OF DEATH: Pneumonia
MANNER OF DEATH: Natural
MEDICAL HISTORY: None
SOCIAL HISTORY: None
FAMILY HISTORY: None
PREVIOUS ILLNESS: None
TREATMENT: None
POST-MORTEM: None
SIGNATURE: [Signature]
DATE: 11-11-1918

11-11-1918

11-11-1918

11-11-1918

1119

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) M CRISFIELD		c. LENGTH OF STAY IN 1b 39	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.		d. STREET ADDRESS SOMERSET AVENUE	
3. NAME OF DECEASED (Type or print) First EUGENE Middle R. Last MILES		4. DATE OF DEATH Month JANUARY Day 6 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-1-1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing Industry		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Mfg.	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBINO MILES		14. MOTHER'S MAIDEN NAME Ozella STIEFF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT BESSIE J. MILES, CRISFIELD, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction (arteriosclerosis) 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 days 10 years 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 59 , to Jan 6 , 19 59 , that I last saw the deceased alive on Jan 6 , 19 59 , and that death occurred at 6:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND DATE SIGNED 1/7/59 ACTUAL SIGNATURE Sarah M. Peyton M.D. PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D. CRISFIELD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md.		24a. REC'D BY REGISTRAR DATE JAN 12 '59	
24b. REGISTRAR'S SIGNATURE Charles L. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1919

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Date of Death		Place of Death		Cause of Death		Disease	
Jan 15, 1919		Boston, Mass.		Heart Disease		Myocardial Infarction	
Time of Death		Occupation		Signature of Physician		Signature of Registrar	
10:30 AM		Carpenter		[Signature]		[Signature]	
Manner of Death		Burial Place		Date of Burial		Name of Burial Place	
Natural		Catholics		Jan 18, 1919		St. Mary's Church	
Signature of Informant		Relationship		Signature of Informant		Relationship	
[Signature]		Son		[Signature]		Son	
Address of Informant		Address of Deceased		Address of Deceased		Address of Deceased	
123 Main St.		123 Main St.		123 Main St.		123 Main St.	
City		City		City		City	
Boston		Boston		Boston		Boston	
State		State		State		State	
Mass.		Mass.		Mass.		Mass.	
County		County		County		County	
Suffolk		Suffolk		Suffolk		Suffolk	
District		District		District		District	
North		North		North		North	
Ward		Ward		Ward		Ward	
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Precinct		Precinct		Precinct		Precinct	
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Section		Section		Section		Section	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1120

CERTIFICATE OF DEATH

011119

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 66 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.		e. STREET ADDRESS SOMERSET AVENUE	
3. NAME OF DECEASED (Type or print) First BEULAH Middle TOY Last POWELL		4. DATE OF DEATH Month JANUARY Day 23 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-92
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWARD MATTHEWS	
14. MOTHER'S MAIDEN NAME MARTHA GREEN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT MINNIE GOLDSBOROUGH, CRISFIELD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dil of Heart. 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Empysematous Gold Colored Heart chot of Coronary Artery DUE TO (c) Chronic Myocarditis Chronic Dil reglular Sino		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 12 , 19 57 , to Jan 23 , 19 59 , that I last saw the deceased alive on JANUARY 23 , 19 59 , and that death occurred at 11:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE George C. Coulbourn M.D. MARION, MARYLAND PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D., MARION, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1959	
22c. NAME OF CEMETERY OR CREMATORY Rehobeth Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Rehobeth, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md.		24a. REC'D BY REGISTRAR JAN 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hous			

CERTIFICATE OF DEATH

1. Name of Deceased: [Illegible]

2. Sex: [Illegible]

3. Age: [Illegible]

4. Date of Birth: [Illegible]

5. Date of Death: [Illegible]

6. Place of Death: [Illegible]

7. Cause of Death: [Illegible]

8. Signature of Physician: [Illegible]

9. Signature of Registrar: [Illegible]

10. Date of Registration: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1121

CERTIFICATE OF DEATH

Reg. Dist. No.

01120

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD CRISFIELD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CRISFIELD - RFD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FREDERICK ADAIL PUSEY</u> First Middle Last				4. DATE OF DEATH <u>JAN 31 1959</u> Month Day Year			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 6 - 1905</u>	9. AGE (In years lost birthday) <u>53</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING - TRUCK DRIVING -</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ADAIL PUSEY</u>				14. MOTHER'S MAIDEN NAME <u>ALICE TULL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-09-1766</u>		17. INFORMANT <u>MRS WANITA PUSEY - CRISFIELD MD.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>260X</u> DUE TO <u>Diabetic Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Few min.</u> <u>Known</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Ischemic Ulcers of left leg - 2 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/6</u> , 19 <u>57</u> , to <u>1/31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/24</u> , 19 <u>59</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. N. Barr, M.D.</u>				ADDRESS (Street, city or town, state) <u>Crisfield, Md.</u>		DATE SIGNED <u>2/2/59</u>	
PHYSICIAN'S NAME (Type) <u>A. N. BARR, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>FEB 4 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SUNNY RIDGE PARK</u>		22d. LOCATION (City, town, or county) (State) <u>HOPEWELL Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Crisfield Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 5 1959</u>	
				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		M		W		4/4/68	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
MEMPHIS, TENN.		4/4/33		MEMPHIS, TENN.		4/4/68		MEMPHIS, TENN.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		METHODIST	
DETAILS OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS DRUGS		PREVIOUS ACCIDENTS	
HEART DISEASE		NONE		NONE		NONE		NONE	
TREATMENT		HOSPITAL		PHYSICIAN		NURSE		PATHOLOGIST	
MEMPHIS HOSPITAL		DR. J. H. HARRIS		MISS J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS	
DATE OF AUTOPSY		PLACE OF AUTOPSY		DATE OF BURIAL		PLACE OF BURIAL		DATE OF BURIAL	
NONE		NONE		4/6/68		MEMPHIS, TENN.		4/6/68	
SIGNATURE OF PHYSICIAN		SIGNATURE OF NURSE		SIGNATURE OF PATHOLOGIST		SIGNATURE OF CORONER		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE		DATE		TIME	
4/4/68		4:00 PM		MEMPHIS, TENN.		4/4/68		4:00 PM	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01121

1122 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Venton		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Z		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Perry Middle W. Last Reese		4. DATE OF DEATH Month January Day 16 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months 82 Days 16 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Reese		14. MOTHER'S MAIDEN NAME Elizabeth Glasgow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Riley Reese, Wilmington, Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Congestion			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 19 58 to Jan. 16 19 59 , that I last saw the deceased alive on Jan. 16 19 59 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Princess Anne, Md DATE SIGNED 1/16/59			
ACTUAL SIGNATURE A.C. Lewis		M.D. Princess Anne, Md	
PHYSICIAN'S NAME (Type) A.C. Lewis, M.D.		Princess Anne, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/59	
22c. NAME OF CEMETERY OR CREMATORY Monie		22d. LOCATION (City, town, or county) (State) Venton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James Herman		ADDRESS Princess Anne, Md	
24a. REC'D BY REGISTRAR JAN 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>Jan 15, 1920</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>Dr. J. B. Smith</u></p>		<p>8. Signature of registrar: <u>John Doe</u></p>	
<p>9. Date of registration: <u>Jan 16, 1920</u></p>		<p>10. Place of registration: <u>Boston</u></p>	
<p>11. Name of informant: <u>John Doe</u></p>		<p>12. Address of informant: <u>123 Main St.</u></p>	
<p>13. Name of informant: <u>John Doe</u></p>		<p>14. Address of informant: <u>123 Main St.</u></p>	
<p>15. Name of informant: <u>John Doe</u></p>		<p>16. Address of informant: <u>123 Main St.</u></p>	
<p>17. Name of informant: <u>John Doe</u></p>		<p>18. Address of informant: <u>123 Main St.</u></p>	
<p>19. Name of informant: <u>John Doe</u></p>		<p>20. Address of informant: <u>123 Main St.</u></p>	
<p>21. Name of informant: <u>John Doe</u></p>		<p>22. Address of informant: <u>123 Main St.</u></p>	
<p>23. Name of informant: <u>John Doe</u></p>		<p>24. Address of informant: <u>123 Main St.</u></p>	
<p>25. Name of informant: <u>John Doe</u></p>		<p>26. Address of informant: <u>123 Main St.</u></p>	
<p>27. Name of informant: <u>John Doe</u></p>		<p>28. Address of informant: <u>123 Main St.</u></p>	
<p>29. Name of informant: <u>John Doe</u></p>		<p>30. Address of informant: <u>123 Main St.</u></p>	
<p>31. Name of informant: <u>John Doe</u></p>		<p>32. Address of informant: <u>123 Main St.</u></p>	
<p>33. Name of informant: <u>John Doe</u></p>		<p>34. Address of informant: <u>123 Main St.</u></p>	
<p>35. Name of informant: <u>John Doe</u></p>		<p>36. Address of informant: <u>123 Main St.</u></p>	
<p>37. Name of informant: <u>John Doe</u></p>		<p>38. Address of informant: <u>123 Main St.</u></p>	
<p>39. Name of informant: <u>John Doe</u></p>		<p>40. Address of informant: <u>123 Main St.</u></p>	
<p>41. Name of informant: <u>John Doe</u></p>		<p>42. Address of informant: <u>123 Main St.</u></p>	
<p>43. Name of informant: <u>John Doe</u></p>		<p>44. Address of informant: <u>123 Main St.</u></p>	
<p>45. Name of informant: <u>John Doe</u></p>		<p>46. Address of informant: <u>123 Main St.</u></p>	
<p>47. Name of informant: <u>John Doe</u></p>		<p>48. Address of informant: <u>123 Main St.</u></p>	
<p>49. Name of informant: <u>John Doe</u></p>		<p>50. Address of informant: <u>123 Main St.</u></p>	
<p>51. Name of informant: <u>John Doe</u></p>		<p>52. Address of informant: <u>123 Main St.</u></p>	
<p>53. Name of informant: <u>John Doe</u></p>		<p>54. Address of informant: <u>123 Main St.</u></p>	
<p>55. Name of informant: <u>John Doe</u></p>		<p>56. Address of informant: <u>123 Main St.</u></p>	
<p>57. Name of informant: <u>John Doe</u></p>		<p>58. Address of informant: <u>123 Main St.</u></p>	
<p>59. Name of informant: <u>John Doe</u></p>		<p>60. Address of informant: <u>123 Main St.</u></p>	
<p>61. Name of informant: <u>John Doe</u></p>		<p>62. Address of informant: <u>123 Main St.</u></p>	
<p>63. Name of informant: <u>John Doe</u></p>		<p>64. Address of informant: <u>123 Main St.</u></p>	
<p>65. Name of informant: <u>John Doe</u></p>		<p>66. Address of informant: <u>123 Main St.</u></p>	
<p>67. Name of informant: <u>John Doe</u></p>		<p>68. Address of informant: <u>123 Main St.</u></p>	
<p>69. Name of informant: <u>John Doe</u></p>		<p>70. Address of informant: <u>123 Main St.</u></p>	
<p>71. Name of informant: <u>John Doe</u></p>		<p>72. Address of informant: <u>123 Main St.</u></p>	
<p>73. Name of informant: <u>John Doe</u></p>		<p>74. Address of informant: <u>123 Main St.</u></p>	
<p>75. Name of informant: <u>John Doe</u></p>		<p>76. Address of informant: <u>123 Main St.</u></p>	
<p>77. Name of informant: <u>John Doe</u></p>		<p>78. Address of informant: <u>123 Main St.</u></p>	
<p>79. Name of informant: <u>John Doe</u></p>		<p>80. Address of informant: <u>123 Main St.</u></p>	
<p>81. Name of informant: <u>John Doe</u></p>		<p>82. Address of informant: <u>123 Main St.</u></p>	
<p>83. Name of informant: <u>John Doe</u></p>		<p>84. Address of informant: <u>123 Main St.</u></p>	
<p>85. Name of informant: <u>John Doe</u></p>		<p>86. Address of informant: <u>123 Main St.</u></p>	
<p>87. Name of informant: <u>John Doe</u></p>		<p>88. Address of informant: <u>123 Main St.</u></p>	
<p>89. Name of informant: <u>John Doe</u></p>		<p>90. Address of informant: <u>123 Main St.</u></p>	
<p>91. Name of informant: <u>John Doe</u></p>		<p>92. Address of informant: <u>123 Main St.</u></p>	
<p>93. Name of informant: <u>John Doe</u></p>		<p>94. Address of informant: <u>123 Main St.</u></p>	
<p>95. Name of informant: <u>John Doe</u></p>		<p>96. Address of informant: <u>123 Main St.</u></p>	
<p>97. Name of informant: <u>John Doe</u></p>		<p>98. Address of informant: <u>123 Main St.</u></p>	
<p>99. Name of informant: <u>John Doe</u></p>		<p>100. Address of informant: <u>123 Main St.</u></p>	

CERTIFICATE OF DEATH

1106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 W. Main St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS 108 W. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First A. Middle NELSON Last SOMERS		4. DATE OF DEATH Month January Day 14, Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS. Days 68 Hours 68 Min. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barbering	
11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Somers		14. MOTHER'S MAIDEN NAME Sally Daugherty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Grace S. Somers, 108 W. Main, Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Cardiac decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Chronic Myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs 5 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1959 to June 10, 1959 , that I last saw the deceased alive on June 10, 1959 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE C. G. Rawley		M.D. Crisfield, Md.	
PHYSICIAN'S NAME (Type) C. G. Rawley, M. D.		Crisfield, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 17, 1959	
22c. NAME OF CEMETERY OR CREMATORY Asbury Methodist Cemetery		22d. LOCATION (City, town, or county) Crisfield, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE JAN 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>AGE [Faint text, possibly "45"]</p>		<p>SEX [Faint text, possibly "Male"]</p>	
<p>DATE OF DEATH [Faint text, possibly "Jan 15, 1925"]</p>		<p>TIME OF DEATH [Faint text, possibly "10:30 AM"]</p>		<p>PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>REPORTED BY [Faint text, possibly "Physician"]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>SIGNATURE OF REPORTER [Faint signature]</p>		<p>DATE OF REPORT [Faint text, possibly "Jan 16, 1925"]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01123

1107

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 334 Cove St.				d. STREET ADDRESS 334 Cpve St.			
3. NAME OF DECEASED (Type or print) First SIDNEY Middle K. Last TYLER				4. DATE OF DEATH Month January Day 17 Year 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1888	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 7 Days 17 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Sidney K. Tyler				14. MOTHER'S MAIDEN NAME Anna Horner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Ralph Landon, 334 Cove St., Crisfield, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Coronary Insufficiency DUE TO (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 3 mo 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 24, 1956 , to Jan 17, 1959 , that I last saw the deceased alive on Jan 14, 1959 , and that death occurred at 6:22 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. N. Barr, M.D. M.D.				ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED 1/19/59			
PHYSICIAN'S NAME (Type) A. N. Barr, M. D.				Crisfield, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 20, 1959		22c. NAME OF CEMETERY OR CREMATORY Asbury Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland				ADDRESS		24a. REC'D BY REGISTRAR JAN 20 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01124

1123

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AMOS		4. DATE OF DEATH Month JANUARY Day 3 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-1877
9. AGE (In years last birthday) yrs. 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM WHITTINGTON		14. MOTHER'S MAIDEN NAME ADELIA MILES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AMOS WHITTINGTON, MARION STATION, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x Uremia Acute Delirium DUE TO Chronic Kidney Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis Cerebral Arteriosclerosis DUE TO Chronic myocarditis Cerebral Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1 , 19 58 to Jan 3 , 19 59 that I last saw the deceased alive on Jan 3 , 19 59 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) MARION STATION, MD. DATE SIGNED George C. Coulbourn			
ACTUAL SIGNATURE George C. Coulbourn M.D. MARION STATION, MD.			
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D., MARION STATION, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 6, 1959	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	22d. LOCATION (City, town, or county) (State) Marion Station, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR DATE JAN 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1108 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	c. LENGTH OF STAY in 1b LIFETIME	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 946 W. BROAD ST.		d. STREET ADDRESS 946 W. BROAD ST.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First TIVOIA Middle WHITTINGTON Last		4. DATE OF DEATH Month JAN. Day 30 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1908
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAFOOD LABORER		10b. KIND OF BUSINESS OR INDUSTRY CRABS & OYSTERS	
11. BIRTHPLACE (State or foreign country) CRISFIELD, MD.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME AL WHITTINGTON		14. MOTHER'S MAIDEN NAME LILLIE MANUEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. LILLIE WHITTINGTON		Address 946 W. Broad St. Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGING FROM NOSE AND MOUTH 783.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EXCESSIVE COUGHING (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---NO SIGNS OF FOUL PLAY---			INTERVAL BETWEEN ONSET AND DEATH minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 5:30 a. m. Jan. 30, 19 59	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Wm H Coulbourn</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM H. COULBOURN		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED Feb. 2, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF FEB. 2, 1959	22c. NAME OF CEMETERY OR CREMATORY LAWSONIA CEMETERY	22d. LOCATION (City, town, or county) (State) CRISFIELD, MD.
23. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS--CRISFIELD, MD.		24a. REC'D BY REGISTRAR FEB 5 '59 DATE	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
HEALTH

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11135

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

